Child Fatality Report

Report Identification Number: SV-22-012

Prepared by: New York State Office of Children & Family Services

Issue Date: Oct 14, 2022

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☒ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☐ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services	DA-District Attorney	
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	SXTF-Sex Trafficking
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 4 year(s)
Jurisdiction: Orange
Gender: Female
Date of Death: 07/22/2021
Initial Date OCFS Notified: 04/29/2022

Presenting Information

An SCR report alleged that on 7/17/21, the mother was driving a vehicle during a torrential downpour of rain and had a severe, head on, accident with another vehicle. The mother allowed the 4-year-old subject child and the 16, 13, 10, 6, and 5-year-old siblings to ride in the vehicle unrestrained without safety belts or child safety seats. The 6-year-old sibling sustained a broken leg. The subject child received CPR at the scene of the accident and was put on life support. She was taken off life support on 7/26/21 and passed away due to the extent of her injuries. The parents were recommended to obtain therapy and mental health supports for the siblings, but they failed to take action to obtain this medical care. The siblings had behavioral struggles, were getting into fights, and were using vulgar language. The parents had sexual intercourse in front of the siblings, knowing the siblings were watching them.

Executive Summary

On 4/29/22, the Orange County Department of Social Services (OCDSS) received an SCR report regarding the death of the 4-year-old female subject child, which occurred on 7/22/21. The report contained additional concerns that the mother failed to obtain mental health care for the siblings following the death of the subject child, and that the parents were engaging in sexual acts in the presence of the siblings. At the time of the subject child's death, she resided with her mother and six siblings, ages 16, 13, 11, 10, 6, and 5. The father of the subject child, 5 and 6-year-old siblings was incarcerated at that time, and he was released on parole following the child's death. The location of the 13, 11, and 10-year-old sibling's fathers were unknown, and the siblings reported they had very little contact with their fathers. The identity of the 16-year-old sibling's father was unknown.

Upon investigation, it was learned that on 7/17/21 at 8:28 PM, the mother was driving her vehicle in a rainstorm when she was hit head on by an impaired driver. The subject child was critically injured in the accident, and she later died from her injuries at the hospital on 7/26/21. The remaining siblings suffered injuries, including fractures and bruising. There were 9 occupants in the mother's vehicle, including the mother, the subject child, five siblings, and two nonrelated persons. The 13-year-old sibling was the only child properly restrained. The 16-year-old sibling did not have a seat belt on, and the remaining four siblings were sharing two seatbelts in the third row of the vehicle. The 11-year-old sibling was not in the vehicle at the time of the accident.

The medical examiner's report stated that the subject child died at the hospital on 7/22/21. Based on an investigation and postmortem examination without autopsy, the cause of death was certified as subdural hematoma and lung contusions due to blunt force injuries. Law enforcement investigated the accident, and the investigation closed with no charges filed.

The mother and siblings became homeless in April 2022, just prior to the SCR report being received. The family was temporarily staying at a motel and then a shelter while they looked for permanent housing. The siblings were assessed to be safe in the mother's care. The father was also homeless, and he declined to meet with OCDSS face-to-face.

OCDSS substantiated the allegations of Inadequate Guardianship, Internal Injuries, Fractures, Swelling/Dislocation/Sprains and Lacerations/Bruises/Welts against the mother regarding the children based on her failure to provide booster seats for the three youngest siblings and for failing to ensure the siblings were properly restrained in the vehicle, resulting in their injury. Per New York State law, based on the three youngest children's ages, height, and weight, they required a booster seat with a lap and shoulder belt and all other occupants were required to wear a seatbelt. There were more occupants in the vehicle than the vehicle was rated for, therefore there were not enough seatbelts for each

person.

OCDSS unsubstantiated the allegation of DOA/Fatality against the mother based on a lack of evidence to support a fair preponderance that the subject child would have survived the accident if properly restrained and the mother's vehicle sustained extensive damage to the side of the vehicle where the subject child was sitting. The allegation of Lack of Medical Care was also unsubstantiated based on a lack of evidence gathered that the mother or father failed to provide the necessary medical or mental health care for the siblings following the accident. OCDSS referred the family for bereavement and mental health services. The school-aged siblings were already receiving counseling services at school and the oldest siblings and parents declined services.

PIP Requirement

For citations identified in historical cases, OCDSS will submit a PIP to the Westchester Regional Office within 30 days of receipt of this report. The PIP will identify action(s) OCDSS has taken, or will take, to address the cited issue(s). For issues where a PIP is currently implemented, OCDSS will review the plan and revise as needed to address ongoing concerns.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Approved Initial Safety Assessment?** Yes
  - **Safety assessment due at the time of determination?** Yes
- **Was the safety decision on the approved Initial Safety Assessment appropriate?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Explain:

The case was appropriately indicated and closed.

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:

Casework activity was commensurate with case circumstances.

Office of Children and Family Services

Child Fatality Report

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐ Yes ☒ No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 07/22/2021 **Time of Death:** Unknown

Date of fatal incident, if different than date of death: 07/17/2021
Time of fatal incident, if different than time of death: 08:28 PM

County where fatality incident occurred: Orange
Was 911 or local emergency number called? Yes
Time of Call: Unknown
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

☐ Sleeping ☐ Working ☒ Driving / Vehicle occupant
☐ Playing ☐ Eating ☐ Unknown
☐ Other

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 1

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	Alleged Victim	Female	4 Year(s)
Deceased Child's Household	Mother	Alleged Perpetrator	Female	32 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	11 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	10 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	6 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	5 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Male	16 Year(s)
Deceased Child's Household	Sibling	Alleged Victim	Female	13 Year(s)
Other Household 1	Other Adult - 13yo Sibling's Father	No Role	Male	41 Year(s)
Other Household 3	Other Adult - 11 and 10yo Sibling's Father	No Role	Male	41 Year(s)
Other Household 4	Father	Alleged Perpetrator	Male	40 Year(s)

LDSS Response

OCDSS investigated the subject child's death by reviewing SCR history, notifying the DA's office of the child's death, and speaking to the source of the report, school staff, and law enforcement. They interviewed the mother, siblings, maternal grandmother, and father and they reviewed records from the school, law enforcement, pediatrician, hospital, EMS, and the 911 call recordings.

The siblings were forensically interviewed at the CAC and they were assessed to be healed from the injuries related to the accident. The siblings confirmed that the mother was driving the vehicle, there was another adult in the passenger seat and the 13-year-old sibling, the 16-year-old sibling, and an unrelated teen were in the middle row. The 10-year-old sibling and subject child were sharing a seatbelt and the 6 and 5-year-old siblings were sharing a seatbelt in the third row. The 16-year-old sibling said he fell asleep during the car ride, and when the car was struck, he became concussed. He woke up in the hospital with a skull and wrist fracture. The 13-year-old sibling said after the accident she unbuckled the seat belt to free the subject child from the vehicle, but she was too weak to pull her out. The 11-year-old sibling said she was not with the mother on the night of the accident, so she was unable to provide any details. The 10-year-old sibling did not provide any other details. The 6-year-old sibling said she was in pain from having broken feet. She and the 5-year-old sibling said they did not have booster seats and it was normal for the youngest children to use just a seat belt. The 5-year-old sibling said she heard a loud noise, and she heard the mother screaming their names.

The mother reported that the subject child was not in a booster seat at the time of the accident, and she was sharing a seat belt with the 10-year-old sibling. She said the 6 and 5-year-old siblings were also sharing a seat belt since there were not enough seat belts for everyone. The mother said she sustained two broken legs, the 13-year-old sibling had a bruised hip, the 6-year-old sibling had two broken feet, the 5-year-old sibling had a sprained ankle, and the 10-year-old sibling had bruising to her lungs. The mother denied engaging in sexual acts in the presence of the children, and she said she offered to obtain mental health counseling for the siblings following the subject child's death, and they declined to participate. The mother did not own booster seats for the 6 and 5-year-old siblings so OCDSS assisted her in obtaining booster seats for her vehicle and she was provided with booster seat training.

The father spoke with OCDSS on the phone, and he confirmed that he was incarcerated at the time of the accident. He said he was allowed to be present at the hospital at the time of the subject child's passing. He denied engaging in sexual activity in the presence of the siblings, and he declined bereavement services.

Law enforcement records showed that the driver of the other vehicle was traveling southbound at a speed not safe for the roadway conditions of heavy rain and they failed to keep right in a curve in the roadway, hitting the mother's vehicle, which was traveling northbound, head on. The other driver was pronounced deceased at the scene from injuries sustained. The other driver's blood alcohol level was 0.154% and they were positive for THC. It was noted that the subject child was not properly restrained in the seat and the vehicle was rated to seat 8 occupants safely; however, there were 9 occupants in the vehicle.

EMS records showed when they arrived at the scene, a bystander had located the child in the backseat of the mother's vehicle in a standard seat belt leaning forward. The bystander performed CPR until EMS arrived and took over life-saving measures. The child regained a pulse, and she was transported by ambulance to the hospital, where she was placed on life support.

Official Manner and Cause of Death

Official Manner: Accident
Primary Cause of Death: From an injury - external cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality investigation conducted by a Multidisciplinary Team (MDT)?Yes

Was the fatality referred to an OCFS approved Child Fatality Review Team?Yes

SCR Fatality Report Summary

Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome
061546 - Deceased Child, Female, 4 Yrs	061547 - Mother, Female, 32 Year(s)	Internal Injuries	Substantiated
061546 - Deceased Child, Female, 4 Yrs	061547 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
061546 - Deceased Child, Female, 4 Yrs	061547 - Mother, Female, 32 Year(s)	DOA / Fatality	Unsubstantiated
061548 - Sibling, Male, 16 Year(s)	061547 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
061548 - Sibling, Male, 16 Year(s)	061547 - Mother, Female, 32 Year(s)	Internal Injuries	Substantiated
061548 - Sibling, Male, 16 Year(s)	061547 - Mother, Female, 32 Year(s)	Inadequate Food / Clothing / Shelter	Substantiated
061548 - Sibling, Male, 16 Year(s)	061547 - Mother, Female, 32 Year(s)	Fractures	Substantiated
061548 - Sibling, Male, 16 Year(s)	061557 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
061548 - Sibling, Male, 16 Year(s)	061557 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
061549 - Sibling, Female, 13 Year(s)	061557 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
061549 - Sibling, Female, 13 Year(s)	061547 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
061549 - Sibling, Female, 13 Year(s)	061547 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Unsubstantiated
061549 - Sibling, Female, 13 Year(s)	061557 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
061550 - Sibling, Female, 11 Year(s)	061547 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
061550 - Sibling, Female, 11 Year(s)	061547 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
061550 - Sibling, Female, 11 Year(s)	061557 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
061550 - Sibling, Female, 11 Year(s)	061557 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated

061551 - Sibling, Female, 10 Year(s)	061547 - Mother, Female, 32 Year(s)	Lacerations / Bruises / Welts	Substantiated
061551 - Sibling, Female, 10 Year(s)	061557 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
061551 - Sibling, Female, 10 Year(s)	061557 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
061551 - Sibling, Female, 10 Year(s)	061547 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
061551 - Sibling, Female, 10 Year(s)	061547 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
061552 - Sibling, Female, 6 Year(s)	061557 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated
061552 - Sibling, Female, 6 Year(s)	061557 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
061552 - Sibling, Female, 6 Year(s)	061547 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
061552 - Sibling, Female, 6 Year(s)	061547 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
061552 - Sibling, Female, 6 Year(s)	061547 - Mother, Female, 32 Year(s)	Fractures	Substantiated
061553 - Sibling, Female, 5 Year(s)	061547 - Mother, Female, 32 Year(s)	Inadequate Guardianship	Substantiated
061553 - Sibling, Female, 5 Year(s)	061557 - Father, Male, 40 Year(s)	Lack of Medical Care	Unsubstantiated
061553 - Sibling, Female, 5 Year(s)	061547 - Mother, Female, 32 Year(s)	Swelling / Dislocations / Sprains	Substantiated
061553 - Sibling, Female, 5 Year(s)	061547 - Mother, Female, 32 Year(s)	Lack of Medical Care	Unsubstantiated
061553 - Sibling, Female, 5 Year(s)	061557 - Father, Male, 40 Year(s)	Inadequate Guardianship	Unsubstantiated

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☒	☐	☐	☐
When appropriate, children were interviewed?	☒	☐	☐	☐
Alleged subject(s) interviewed face-to-face?	☒	☐	☐	☐
All 'other persons named' interviewed face-to-face?	☐	☒	☐	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐

Was there discussion with all parties (youth, other household members, and staff) who were present that day (if nonverbal, observation and comments in case notes)?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Additional information:

Attempts to locate and interview the fathers of the 13, 11 and 10-year-old siblings were unsuccessful.

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of impending or immediate danger to surviving siblings/other children in the household named in the report:				
Within 24 hours?	☒	☐	☐	☐
At 7 days?	☒	☐	☐	☐
At 30 days?	☒	☐	☐	☐
Was there an approved Initial Safety Assessment for all surviving siblings/ other children in the household within 24 hours?	☒	☐	☐	☐
Are there any safety issues that need to be referred back to the local district?	☐	☒	☐	☐

When safety factors were present that placed the surviving siblings/other children in the household in impending or immediate danger of serious harm, were the safety interventions, including parent/caretaker actions adequate?	☐	☐	☒	☐

Fatality Risk Assessment / Risk Assessment Profile

	Yes	No	N/A	Unable to Determine
Was the risk assessment/RAP adequate in this case?	☒	☐	☐	☐
During the course of the investigation, was sufficient information gathered to assess risk to all surviving siblings/other children in the household?	☒	☐	☐	☐
Was there an adequate assessment of the family's need for services?	☒	☐	☐	☐
Did the protective factors in this case require the LDSS to file a petition in Family Court at any time during or after the investigation?	☐	☒	☐	☐
Were appropriate/needed services offered in this case	☒	☐	☐	☐

Explain:
Risk was adequately assessed and the appropriate services were offered.

Placement Activities in Response to the Fatality Investigation

	Yes	No	N/A	Unable to Determine
Did the safety factors in the case show the need for the surviving siblings/other children in the household be removed or placed in foster care at any time during this fatality investigation?	☐	☒	☐	☐
Were there surviving children in the household that were removed either as a result of this fatality report / investigation or for reasons unrelated to this fatality?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☐	☒	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☒	☐	☐	☐
Housing assistance	☒	☐	☐	☐	☐	☐	☐
Mental health services	☐	☒	☐	☐	☐	☐	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☒	☐	☐	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐

Other	☐	☐	☐	☐	☐	☒	☐

Were services provided to siblings or other children in the household to address any immediate needs and support their well-being in response to the fatality? Yes
Explain:
The school-aged siblings received counseling services at school. All six siblings were referred for additional bereavement services and they declined.

Were services provided to parent(s) and other care givers to address any immediate needs related to the fatality? No
Explain:
The parents were referred for bereavement services and they declined.

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was the child ever placed outside of the home prior to the death?	No
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
12/01/2020	Sibling, Male, 15 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	No
	Sibling, Female, 12 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 10 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	
	Sibling, Female, 9 Years	Mother, Female, 32 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 15 Years	Mother, Female, 32 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 15 Years	Mother, Female, 32 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report alleged that the four oldest siblings were excessively absent from in-person and remote learning sessions during the 2020-2021 school year. The siblings were missing significant academic content and were failing as a result. The mother was aware that the siblings were not participating and had taken minimal action to facilitate their participation. The oldest sibling received mental health counseling at school and due to his absences, he had not been participating. The oldest sibling had a history of acting out behaviors and the mother was unable to control and manage these behaviors.

Report Determination: Unfounded | **Date of Determination:** 01/21/2021

Basis for Determination:
The children were attending school based on a hybrid model and the mother was struggling with managing the schedules of the five school-aged children. The mother was in contact with school staff regarding the barriers she was facing and

she was receptive to services. The school allowed some of the siblings to attend school remotely from the school cafeteria with the assistance of aides to complete their assignments. The oldest sibling continued to refuse to attend school or to complete assignments. The mother agreed to all recommended services and she attended a school meeting. The mother agreed to preventive services to assist her with managing the school schedules.

OCFS Review Results:
The mother and children were interviewed and the home was assessed to be safe. Safety Assessments and the RAP were completed timely and accurately. Notice of Existence was provided to the required adults. OCDSS spoke to school staff and reviewed school and pediatrician records. The family was appropriately referred for preventive services.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Allegation Outcome	Compliance Issue(s)
04/30/2019	Sibling, Female, 11 Years	Aunt/Uncle, Male, 24 Years	Other	Unsubstantiated	No
	Sibling, Female, 9 Years	Aunt/Uncle, Male, 24 Years	Other	Unsubstantiated	
	Sibling, Female, 7 Years	Aunt/Uncle, Male, 24 Years	Other	Unsubstantiated	
	Sibling, Female, 4 Years	Aunt/Uncle, Male, 24 Years	Other	Unsubstantiated	
	Sibling, Male, 13 Years	Aunt/Uncle, Male, 24 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Female, 3 Years	Aunt/Uncle, Male, 24 Years	Other	Unsubstantiated	
	Deceased Child, Female, 2 Years	Aunt/Uncle, Male, 24 Years	Other	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 30 Years	Inadequate Guardianship	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 30 Years	Educational Neglect	Unsubstantiated	
	Sibling, Male, 13 Years	Mother, Female, 30 Years	Lack of Medical Care	Unsubstantiated	

Report Summary:
An SCR report alleged that on 4/28/19, the now 16-year-old sibling and the mother had an argument. The maternal uncle intervened and threw the sibling into a wall, then punched him in the chest and body. The mother was present and did not intervene. The uncle had been physical with the sibling many times and it was unknown if the sibling had ever been injured. The uncle was a registered sex offender and he had contact everyday with the siblings and subject child. It was unknown if the mother was aware of his sex offender status. A subsequent report dated 4/20/19 alleged the oldest sibling had excessive school absences and the mother was failing to meet his educational and medical needs.

Report Determination: Unfounded | **Date of Determination:** 06/28/2019

Basis for Determination:
The uncle did not reside in the home. He was a registered sex offender but he denied being alone with the children and the children did not disclose being sexually abused by him. The mother reported there was an incident where she told the oldest sibling to bring the video gaming system into his bedroom but he did not listen so the uncle unplugged it. The oldest sibling became enraged and he threw the game controller at the TV and wall. He then pushed the uncle. The uncle

left the home, hoping the sibling would calm down. The mother contacted law enforcement, who responded to the home. The case remained opened for preventive services.

OCFS Review Results:
Home visits were conducted and the mother and children were interviewed, with the exception of the oldest sibling, who would not engage with the caseworker. Attempts to interview the uncle and to speak to the fathers of the younger siblings were unsuccessful. Safety Assessments and the RAP were completed timely and accurately. Relevant collaterals were contacted, including probation, school staff, a community agency and the maternal grandmother. The oldest sibling continued to receive services through a community agency and probation.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
03/04/2019	Sibling, Male, 13 Years	Mother, Female, 30 Years	Educational Neglect	Far-Closed	Yes
	Deceased Child, Female, 1 Years	Grandparent, Female, 56 Years	Burns / Scalding	Far-Closed	
	Deceased Child, Female, 1 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Deceased Child, Female, 1 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Female, 11 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Female, 11 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Far-Closed	
	Sibling, Male, 13 Years	Grandparent, Female, 56 Years	Educational Neglect	Far-Closed	
	Sibling, Male, 13 Years	Grandparent, Female, 56 Years	Inadequate Food / Clothing / Shelter	Far-Closed	
	Sibling, Male, 13 Years	Grandparent, Female, 56 Years	Inadequate Guardianship	Far-Closed	

Report Summary:
An SCR report was tracked FAR that alleged the now 16-year-old sibling missed 46 days of school so far during the 2018/2019 school year and he was failing as a result. There was a history of excessive absenteeism and he had been held back in the past as a result. The mother was aware, but failed to adequately address the situation. A subsequent report dated 4/12/19 was merged and it named the maternal grandmother as the subject. There were allegations regarding the now 16-year-old sibling's attendance, the subject child sustained a burn to her arm, the mother was verbally and physically aggressive towards the children, and concerns regarding the condition of the home.

OCFS Review Results:
OCDSS assessed the mother's home and they interviewed the mother and children. Notice of FAR and Notice of FAR closing were provided to the mother and fathers. The grandmother was the subject of the 4/12/19 report; however, the Call Narrative referred to her as the mother. This discrepancy was not addressed and the grandmother was not interviewed or engaged in the FAR case. Service needs were assessed and the FLAG was completed. The oldest sibling was receiving services from probation and a community agency. The family's service needs continued to be assessed in a subsequent CPS investigation.

Are there Required Actions related to the compliance issue(s)? ☒Yes ☐No

Issue:

FAR-Failure to Provide Notice of Report

Summary:

The grandmother was not provided with the Notice of FAR or FAR closing letters.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a)-(d)

Action:

No later than seven days after receipt of a child protective report that has been assigned to the Family Assessment Response track, the child protective service must provide written notification to every parent, guardian or other person legally responsible for the child or children named in the report.

Issue:

FAR-Failure to Engage a Parent, Guardian or Other Person Legally Responsible

Summary:

Attempts to interview the grandmother were not documented.

Legal Reference:

18 NYCRR 432.13 (e)(2)(i)(a-d); 18 NYCRR 432.13(e)(2)(iii)

Action:

Family assessment response workers must work in partnership with the families participating in a family assessment response. Workers should be transparent with families regarding all actions that they take regarding the case. To the extent feasible, child protective service workers should include all family members in discussions, including children who are old enough to express opinions, as well

Issue:

FAR-Timely/Adequate Documentation

Summary:

The grandmother was the subject of the subsequent SCR report; however, the Call Narrative referred to her as the mother. This discrepancy was not addressed so the case documentation was not consistent with the allegations.

Legal Reference:

18 NYCRR 432.13 (e)(5)

Action:

Activities conducted as part of a family assessment response case must be documented in CONNECTIONS in the form and manner prescribed by OCFS.

CPS - Investigative History More Than Three Years Prior to the Fatality

An SCR report dated 11/16/12 was unsub for the allegations of IG and PD/AM against the mother and maternal uncle regarding the four oldest siblings as well as LS and B/S regarding the now 11-year-old sibling.

An SCR report dated 4/24/14 was unsub for the allegation of IG against the mother, maternal grandmother and another adult regarding the now 13-year-old sibling and two other children.

An SCR report dated 8/15/14 was unsub for the allegation of Oth/COI against the mother, maternal grandmother and the fathers of the siblings regarding the now 13, 11 and 10-year-old siblings.

An SCR report dated 5/29/15 with the allegation of IG against the mother regarding the now 6-year-old was tracked FAR.

An SCR report dated 11/12/15 was unsub for the allegations of B/S and IG against the mother regarding the now 10-year-old sibling.

An SCR report dated 4/12/17 was unsub for the allegations of IG and PD/AM against the mother regarding the subject child.

An SCR report dated 9/20/17 with the allegations of IF/C/S, IG and LS against the mother and the maternal uncle regarding the 5 youngest siblings and the subject child was tracked FAR.

An SCR report dated 1/9/18 with the allegations of IF/C/S, IG and L/B/W against the mother regarding the 5 youngest siblings and the subject child, XCP regarding the now 5-year-old sibling, and EdN regarding the now 13 and 10-year-old siblings was tracked FAR.

Known CPS History Outside of NYS

There is no known CPS history outside of New York State.

Preventive Services History

Preventive Services cases were opened from 11/2/09-12/7/09, 4/29/10-9/2/10 and 7/18/11-8/23/11 due to self referrals from the mother. She requested assistance with housing and in obtaining community services.

A Preventive Services case was opened from 7/20/15-8/27/15. The mother and siblings were homeless, the mother had a history of substance misuse and she was not engaged in treatment. The oldest sibling resided with the grandmother. The case closed since there was an open FAR case.

A Preventive Services Case was opened from 4/1/19-7/30/20. The oldest sibling returned to the mother's care in June 2018. The mother filed a PINS against him due to truancy and behavioral issues and the sibling was placed on probation due to criminal charges. The mother engaged in services but the sibling did not follow through with drug treatment, he did not participate in required services and he did not attend school. The family moved and the case closed due to the sibling's lack of compliance with programming.

A Preventive Services Case was opened from 1/12/21-6/29/21. The mother was having difficulty managing the siblings' virtual schedules and they were failing. The oldest sibling refused to attend school or participate in services. The oldest sibling turned 16 and the mother planned to disenroll him from school. The case closed at the end of the school year at the mother's request.

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity.

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No